COMMUNITY SUPPORTS

INFORMATION GUIDE

Developmental Disabilities Program

Disabilities Services Division

Revised May 1, 2004

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Definition

Community Supports includes any individually designed service, or assessment of the need for service, that will assist a consumer to live more independently in the community of his/her choice within the dollar cap established. The funding is individualized and portable. That is, an individual's Community Supports Plan will be written to meet the specific needs of the individual and the individual may receive those supports in the location of his or her choice.

Depending upon the needs of the individual, any one or more than one of the following services may be included as a **Community Support** service. (This is not meant to be an exhaustive list.)

Adaptive equipment/environmental modifications/ assistive technology;
Basic academic skills (reading, writing, math, etc.)
Daily living skills (assistance with eating, bathing, toileting, transferring, dressing, grooming);
Communication skills (oral, written, nonverbal);
Consumer affairs and rights (familiarity with warranties, policies, and procedures of governmental and community agencies);
Contingency planning, problem solving and decision making;
Developing socially and age appropriate behaviors;
Financial management, including techniques of purchasing, banking, handling taxes, budgeting, and repaying debts;
Health maintenance (personal hygiene, exercise and fitness, nutrition an diet management, infection control, use of medicines and medical services);
Housekeeping and home maintenance skills;
Interpersonal relationships, including those with the individual's spouse, family members, and friends;
Life issues and transitions (leaving home, substance abuse, parenting, divorce, retirement, death, sexuality, etc.)

Management of personal and legal affairs;
Menu planning and meal preparation;
Mobility and community transportation skills;
Leisure time activities;
Respite;
Safety practices, including dealing with injuries and life-threatening situations;
Self advocacy and assertiveness training;
Transportation services;
Use of the telephone;
Utilization of community services and resources (laundromat, library, post office, consumer affairs office);
Work Services, work behaviors and skills exploration.

Examples of specific types of services purchased through this program (to date) are: computer hardware and software; social outings; specialized wheelchair; educational courses/books/tapes; orthopedic shoes; humidifier; dental crowns; tires; auto repair; and recognized alternative therapies.

Community Supports Eligibility

To be eligible for Community Supports an individual must be

1) determined eligible for developmental disabilities services;

2) an adult (18 or over).

The individual may not

1) be a recipient of Waiver Funds if residing in a nursing home. Those few individuals who were in a nursing home whose Community Supports Plans were in place prior to July 1, 2000 may continue with Community Supports services through State General Fund.

2) receive any other DDP-funded service other than DD Case Management, Home Health transferred Nursing Services and those services related to fulfilling adaptive equipment needs. An individual receiving other DDP funded services may be on the Community Supports Waiting list but at the time CS funding is accepted and an agreement is in place all other DDP funded services must be discontinued with the exception so noted in this section.

An individual who receives other traditional DDP-funded services will be eligible for a service exchange if he or she is willing to give up the traditional service in exchange for Community Supports and it is determined that the individuals health and safety needs can be met by the limited dollar funding in Community Supports.

Individuals with personal assets determined Medicaid eligible are also eligible for Waiver funded Community Supports.

Individuals may not accept a Community Supports placement unless their health and safety needs can be met by the Community Supports limited dollar program.

Waiting List Procedures

Waiting for Community Supports

A waiting list has been designed specifically for Community Supports. Individual's eligible for Developmental Disabilities Services, with reasonable expectation that health and safety needs will be met by the Community Supports Program, will be assisted by a Case Manager to select a desired start date, a preferred city and be placed on the Community Supports Waiting List for their region of residence whether or not the "preferred city" is in the individual's region of residence. The Desired Start Date can not be a date prior to the day they are requesting placement on the Waiting List. If an individual moves to a new region the desired start date remains the same.

Any individual eligible for Developmental Disabilities Services (age 18 or older), with reasonable expectation that his/her health and safety needs will be met by the limited dollar Community Supports Program may choose to be on the Community Supports Waiting List. Individuals can not be placed on the waiting list before they are seventeen and a half years of age. Individuals may be on more than one Waiting List but can only be receiving services from one Waiver at a time.

General Fund dollars will be used to fund only individuals who do not qualify for Waiver Services, those with Trust Funds and Spend Down requirements will also be subject to this policy.

All referral packet documentation must be received by the Quality Improvement Specialist before an individual can be placed on the Community Supports Waiting List.
Referral Packet requirements are:
*Referral Cover Letter
*Psychological Evaluation
*Documentation of Eligibility
*Social History
*Skills Assessment
*Residential Support Grid (if necessary)

*Risk Needs Planning Assessment

Individuals who are currently on the Waiting List as of September 1, 2001, may remain on the list if they are eligible for adult Developmental Disabilities Services and there is reasonable expectation that their health and safety needs can be met by the limited dollar Community Supports Program.

Selected for Community Supports

Any time two or more individuals in the same region choose the same desired start date a random selection process will occur when a Community Supports opportunity becomes available. The individual(s) not selected will be first in line for the next available opportunity.

As individuals leave Community Supports Services, or choose not to accept them the available Community Supports opportunity will be offered to the individual(s) with the next desired start date.

If an individual has been selected to receive, or is receiving Community Supports, and has also been selected for, or is receiving, another DDP-Funded service, then that individual will be required to choose between the two services. In other words, that individual would be required to either give up their Community Supports or turn down, or give up, the other DDP-Funded service. This applies to recipients of Family Education and Supported Living, or Follow-along Services (Respite), as well as other DDP-funded services, but does not apply to DD Case Management, Home Health transferred Nursing Services and services from the Montana Adaptive Equipment Program.

Recipients of other (non-DDP-Funded) Department of Public Health and Human Services (DPHHS) or other services are not precluded from receiving Community Supports. Community Supports, however, must not duplicate any other service or services that the individual is receiving.

A person has 3 months to accept or decline a Community Supports opportunity and have a CS Agreement in place. Once a CS Agreement is signed the individual should be removed from the wait list. If a person refuses a Community Supports opportunity at the time it is offered the funds can not be reserved for him/her. If the individual is still interested in a Community Supports Agreement they must choose a new desired start date.

* At the time an individual is designated to receive Community Supports Services the Case Manager must verify that health and safety needs can be met.

Health and Safety Needs Planning Process

A. Case Manager speaks to person/family about Community Supports, and works with person/family to identify health and safety needs. Case Manager fills out the Risk/Needs Planning Assessment form. (RPA)

   Case Manager explains the parameters of Community Supports, describing the potential benefit and realistic limitations. For example, although there is probably enough money to purchase a day program, there will not be enough to purchase residential services as well.

   Case Manager informs the family that the Quality Improvement Specialist and Nurse Coordinator will be making an appointment with them to do a level of care determination which is a requirement for Waiver funding.

B. Quality Improvement Specialist (QIS) and Nurse Coordinator complete level of care for DD Waiver Candidates.

C. Case Manager distributes provider information. All potential providers should have information available for Case Managers to distribute. Case Manager discusses the list of possible questions to ask providers. A suggested list is included in this handbook.

D. Case Manager gets referral information to potential providers. The RPA Form and signed release of information should be included in the referral packet. (Note: The person/family may wish to meet with potential providers prior to distribution of their referral packet. This would serve to narrow the field of providers, or help the person/family select the one or two providers from whom they will choose to receive services.)

E. Person/family meets with a provider or providers. Case Manager attends if requested. Person/family and provider go over specifics of the Risk/Needs Planning Assessment form and other information necessary to develop a service proposal and cost plan. Person/family should gather enough information from provider to know if this is a provider from whom they would like to receive services. Provider should gather enough information to develop a service proposal and cost plan.

F. Based on the initial meeting and other information, the person/family chooses a preferred provider. If needed, the person/family could request a follow-up meeting with the provider or providers before making this decision. The person/family could also choose to decide between providers after the service proposal and cost plan are developed.

Note: If either the consumer or family member doesn't like what the provider can do for them, or the provider just can't do what is being asked of them, the Developmental Disabilities Program Regional Manager, will evaluate the situation to determine which traditional, or non-traditional providers of services to refer to the consumer, or family member to best meet their needs.

G. When the eligible person has selected a provider from whom they are interested in receiving services, the Case Manager will assist them in

notifying the Executive Director of the selected provider and the providers that were not selected.

H. Provider develops a cost plan and service proposal to present to person/ family, with the Case Manager available upon request. If agreement is reached, the provider notifies the Case Manager and DDP.

I. A Service Agreement is developed and presented to DDP for approval. If approved, Case Manager is notified. If not approved, the Regional Manager or Quality Improvement Specialist will notify the provider and Case Manager.

J. Service Agreements may only be revised twice within a fiscal year. Therefore essential needs planning must be thought out carefully.

K. The Case Manager notifies person/family of approval and schedules IP meeting. Services begin as specified in the Service Agreement, or as modified by the IP team. Any service modifications must not exceed the total dollar amount of the Community Supports Service Agreement unless so specified in the approved Waiver. Exceptions are: Unusual Transportation needs and Private Duty Nursing.

COMMUNITY SUPPORTS
ANNUAL RISK/NEEDS PLANNING ASSESSMENT FORM (RPA)

Name:_____ Address:_____

DOB:_____RPA Source:_____

CM:_____ RPA Date:_____

Instructions- The Risk/Needs Planning Assessment Form (RPA) was developed in response to CMS health/safety concerns associated with a limited dollar Medicaid-funded service. It is reviewed annually for persons receiving CS, or on the waiting list for CS. The RPA should be completed by phone or face to face visit with a primary care-giver or family member. The form should be completed prior to the development of the Service Agreement for persons entering services. The supports outlined in the C S Service Agreement should address the critical health/safety issues identified in the RPA. Those persons whose critical needs cannot be addressed with the resources available in CS should be targeted for services capable of meeting critical needs. The RPA will be maintained in the Case Manager files.

POTENTIAL SUPPORT OPTIONS * *italics* = available only to age 21

Montana State Plan Medicaid Services: audiology and hearing aides, dialysis, *outpatient chemical dependency*, *chiropractic*, mental health, dental, *dietician*, optometric exams, eyeglasses, family planning, home health, hospice, hospital, durable medical equipment, prosthetic devices and medical supplies, lab and X-rays, drugs, home infusion therapy, physical therapy, speech therapy, *school based services*, occupational therapy, physician, podiatry, mid-level practitioner services, transportation and ambulance, lab and X-ray, personal assistant, nursing services, *respiratory therapy,* transportation, *Early Periodic Screening Diagnosis & Treatment*, Indian health services, health insurance, Medicare buy in, and other services (talk to your case manager).

Community Supports Services (maximum allowed is $7,800, except for private duty nursing and/or assistance with motor vehicle purchase under the transportation category): homemaker, personal care, respite, residential and day/work habilitation, environmental modifications, transportation, specialized medical/adaptive equipment, adult companion, private duty nursing, social/leisure/rec supports, health/health safety supports, educational services.

_____

BACKGROUND INFORMATION

Person eligible for SSI/Medicaid?_____
Person eligible for SSA/Medicare?_____
Does the person need a representative payee?_____
Do family and/or friends help out? _____
_____

Does the person access generic community resources? _____
_____
Does the individual require 24 supervision?_____
_____
Does the person need minimal direct services such as money management, apartment checks, help with appointments, etc?_____
Are there outstanding health/safety issues?_____
_____

PRIORITIZED NEEDS

(insert a # from 1 to 5) 1= minor need, 5= primary need NN= not a current need

ranking	**need category**	**comments**
___	housing	_____
___	food/nutrition	_____
___	need for help for care giver	_____
___	need for more care giver free time	_____
___	transportation issues	_____
___	mental health treatment issues	_____
___	health care/medical issues (identify)	_____
___	communication skills	_____
___	behavioral issues (identify)	_____
___	meaningful friendships/ relationships	_____
___	issues with sleep or night time behaviors	_____
___	abuse, neglect or exploitation risks	_____
___	work or day activities	_____
___	clothing	_____
___	stress factors for person with DD	_____
___	stress factors for primary care giver(s)	_____
___	adequacy of financial resources	_____
___	leisure/rec opportunities/choices	_____
___	personal hygiene	_____
___	other	_____

From the list of potential support options and a review of the need categories, list the supports or activities needed to resolve the significant areas of concern:_____
_____
_____
What is the greatest source of care-giver or consumer stress, and what would help to alleviate this stress? _____
What is the one thing that we could do to make a critical difference in the individual's life?____
_____

FORM PHHS-DD-21

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
RELEASE OF CONFIDENTIAL INFORMATION

AUTHORIZATION TO MONTANA PUBLIC HEALTH AND HUMAN SERVICES TO OBTAIN PERSONAL INFORMATION

Client's Name _____ SSN_____
(Last) (First) (Middle) (9 digits)

Address
(Street) (City) (State) (Zip Code)

I authorize the individual, company or agency shown below to disclose to the Department of Public Health and Human Services, the information specified below. It has been explained to me that information about the types of programs and the amount of progress I show in them will be monitored by the Developmental Disabilities Program and may be electronically stored for future use. I understand that any information obtained will be kept confidential and will be used only for purposes directly connected with the administration of services.

INFORMATION SOURCE:

INFORMATION TO BE REQUESTED:

(For a child, signature of parent or legal guardian -- For an adult, signature of adult or legal representative)
(**Please print name/relationship below signature**)

X_____ Date_____

Individual Planning Process

The Developmental Disabilities Program's new program, Community Supports, began October 1, 1999. This flexible, individualized service was created and implemented by DDP staff in order to meet the Health and Safety needs of Montana's consumers with DD and, thereby, reduce the wait list for DD services.

Individuals who elect to receive Community Supports have the same right to an Individual Plan (IP) as other DDP-funded individuals. Individual Plans are required by the Medicaid Waiver and accrediting agencies as well.

The Community Supports Agreement is the agreement worked out between the family or individual and the service providers (with assistance as needed from Case Management and DDP). It must be written in detail sufficient to define the service, the frequency of service, the location of the service and the cost.

The Community Supports Agreement, if written in sufficient detail, may be substituted for the objectives page of the Individual Plan.

An IP team may **recommend** additional hours or additional services beyond those specified in the Community Supports agreement. Any additional needs that are written into the Individual Plan that result in additional responsibility and expense to the Community Supports provider(s) will trigger a re-negotiation of the Community Supports Agreement. Implementation will be contingent on the agreement of the corporation director, or a different provider can be approached. The individual and family, the Case Manager and DDP personnel will assist in securing another provider if necessary.

The Case Manager will need to seek advice on costs from providers or the Regional Manager. In no case will the team develop an Individual Plan that exceeds the annual allocation of $7800. With the exceptions specified in the approved Community Supports Waiver for unusual transportation needs and Private Duty Nursing.

If the individual receives only an item or one-time service, such as the purchase of equipment or other environmental modification, the Community Supports Agreement attached to the Individual Service Plan, may serve as the required plan of care, since there would not be a "team" as such, to work with.

If Respite is the only service purchased by a Community Supports recipient, an IP is not required and the Community Supports Agreement may substitute as the plan of care.

If an individual chooses an agency to be his/her provider, who is not currently trained in the Individual Plan (IP) Rule, the Quality Improvement Specialist provides necessary training. (See the Qualified Provider policy, page 53.) Some providers may not be required to participate in the IP process. An example of these providers is the one who just builds a ramp.

If a crisis situation emerges, the Case Manager, at the request of the team, can request crisis funds from the Regional Manager.

The descriptions below, in **bold**, are examples of possible Community Supports Agreement narratives:

> **Example A. John will receive day services at an annual cost of $6500 (which is the rate charged for all individuals attending that particular day program.) His mother has agreed to provide transportation on a daily basis and will be reimbursed for mileage up to $100 per month. John's total Community Supports plan will be $7700.**
>
> The IP team might talk about whether John's family or Case Manager will need to arrange for any medical or dental exams; whether he is receiving all of the government or other benefits he might be eligible for such as food stamps, energy assistance, personal care; and whether he needs help finding a ride to social club on Thursday nights, since that's his mom's bowling night. They will discuss reasonable training or work objectives for John to work on at the day program. Maybe they will discuss referring

John for a work evaluation.

Example B. An Habilitation Aide will be employed by X Corporation to provide support to Alice for an annual cost of $3910 per year. Alice and her family will receive additional supports on weekends and evenings up to a maximum of $2000 annually. Alice's annual Community Supports plan totals $5910.

(Note: this was figured at: $7/hr + $3/hr benefits x 4 hours/week, 47 weeks a year + 10 meeting and training hours for the hab aide = $1980. $1330 budgeted for transportation, activities and supplies. $600 for supervision, office space, telephone or other administrative costs.)

The IP team will talk about meeting Alice's Health and Safety needs. They will also talk with the Hab Aide about appropriate activities. Alice may need to learn appropriate behavior in a store and how to purchase small items. She may need to learn a leisure skill that might involve trying a number of crafts or other projects. She may need an escort to attend People First meetings until she can attend without assistance. Since Alice's cost plan does not equal $7800. Alice may want to enroll in an Adult Learning Class to improve her reading skills. The Case Manager might agree to look into the cost of the Adult Learning Class, including talking to the director of X Corporation to see if the corporation would be willing to make the payment to the Adult Learning Center, and report back to Alice and her team, before a decision is made.

If Alice and her team agree that the Adult Learning Class would be beneficial, the Community Supports Agreement would need to be revised to reflect the additional dollars. The payment could be made through Corporation X or directly to the Adult Learning Center if it is determined to be a "Qualified Provider."

Example C: Corporation Z will provide day services to Sally for an annual cost of $5000 (which is less than the rate charged to the DDP contract for other individuals.) Sally will

participate in contract work when it is available, social and leisure activities. She will not have individual training objectives. Sally's mother will transport Sally to Corporation Z's Avenue B group home so that Sally can ride to the day program with the group home residents. Corporation Y will provide up to $2800 annually for additional support evenings and weekends for Sally and her family.

Sally and her IP Team will discuss her Health and Safety needs and generic services that might be available to Sally. The team may discuss the need to refer Sally to VR for a work evaluation and possible supported employment. They will clarify with corporation staff whether they will take responsibility for supervising Sally's afternoon medications.

INDIVIDUAL SERVICE PLAN
DEVELOPMENTAL DISABILITIES CASE MANAGEMENT

Individual: _____ Case Manager:

Planning Date:

SERVICE OBJECTIVE	RESPONSIBLE PERSON	TARGETED COMPLETION DATE	COMPLETI DATE

COMMENTS:

_____ _____ _____ _____

Individual Served Date Family or Friend Date

_____ _____ _____

Case Manager Date Case Mgt. Supervisor Date

Possible Questions to Ask Providers of Community Supports (For Recipients of Community Supports and Their Care Givers)

1. How long has your agency provided services to persons with Developmental Disabilities?

2. How many people do you work with?

3. Could I contact individuals and/or family members who receive services from your agency?

4. How many hours of assistance will I (or my son/daughter) receive from your agency each week?

5. Can I be involved in hiring staff that will work with me?

6. Will staff let me work with them to develop a schedule that will best meet my (or my son's/daughter's) needs?

7. If things change in my (or my son's/daughter's) life, can I (or my son/daughter) schedule different times to meet with staff?

8. What qualifications/experience do your staff have?

9. Is your program accredited?

10. Does your agency have an efficient way to respond to emergencies? How does your agency respond to emergencies? What is your on-call system?

11. If staff quit, are ill or go on vacation, are there backup staff who can immediately work with me (or my son/daughter)?

12. If for "good" reason I am, (or my son/daughter) is dissatisfied with staff performance, will your agency help solve this problem or can I (or my son/daughter) begin working with a new staff person?

13. Will your agency help me (or my son/daughter) coordinate Personal Care or other services we might need?

14. What are the different living environments in which I (or my son/daughter) could live?

15. How would you provide for my safety and health?

16. What educational and instructional services do you provide?

17. What opportunities do you provide to meet social, recreational and leisure needs?

18. What training does your agency provide for staff?

19. What philosophy do you have on services to people with Developmental Disabilities? Please give me some examples of how the delivery of services matches your philosophy.

20. What role does the family play in services, and how is the family's involvement viewed by the service provider?

21. Can I visit/tour one of your service locations?

22. What do you do during the first 30 days of placement before the initial IP?

23. What is your grievance procedure? How do I resolve a difference or disagreement with you? If we cannot resolve our differences, what options do we have? (Note: Fair hearing with DPHHS should be one of the options.)

24. Explain your confidentiality policy.

25. How do you assess the effectiveness of the IP plan? Under what kind of time lines is the plan reviewed?

26. How would you help me (or my son/daughter) become involved

in the life of the community?

27. What kind of assistance would you provide me with . . . (managing my money, finding a job, shopping, or other need)?

28. If the IP team agrees on a certain level of support, how are team members notified of, and when would they need to approve, changes of staff/support?

29. What would you do if . . . (fill in with pertinent situations)?

Community Supports Agreement

A Community Supports Agreement may be written with current DDP Contractors as an adjunct to the principle contract or a separate Community Supports Contract may be written with a qualified provider (see section on Qualified Provider, page 53). A Community Supports Contract may be obtained from the Regional Manager.

Procedure:

1. The individual on the waiting list already has an assigned Case Manager and a complete referral packet.

2. The Case Manager and the individual will complete a Risk/ Needs Planning Assessment with the assistance of a family member or care giver.

3. The Case Manager will discuss with the family the total funds available under Community Supports, the program guidelines, and suggest ideas for meeting the individual's health and safety needs. Funds available annually are capped at $7800. Funds available for part of a fiscal year will be pro-rated according to the number of months left in the year.

Note: A "pro-rated" amount is determined by dividing $7800 by 12 and multiplying the result by the number of months remaining in the year. For example, if the individual starts services in January, there are 6 months remaining in the fiscal year, 6 months x $650/month = $3900 for the remainder of the year. $7800 will be available for the next full fiscal year.

4. The Case Manager will inform the individual and his/her family of potential providers and assist the individual and anyone he/she would like to have accompany him/her to meet with potential providers to discuss his/her health and safety service needs and the provider's estimated costs for meeting such needs. For the convenience of the individual and his/her family, in some cases, the provider may meet with them in their home (or home

community.)

5. The individual will indicate which providers his/her referral packet should be given to.

6. The provider if wishing to provide service to the individual will write a service proposal, including costs, to assist the individual to make a choice among possible providers.

7. A copy of the service proposal(s) will be given to the DDP Regional Office to determine whether costs are allowable and reasonable. The service proposal would then be included in the narrative section of the Community Supports Agreement.

8. When the individual makes a choice, the Community Supports Agreement will be executed among all parties listed on the form and sent to the appropriate DDP Office.

9. The Regional Office will complete an ISR, assign payment codes (XIX or GF) and authorize payment before entering on AWACS (the computerized payment system).

10. Providers will be issued pre-printed invoices.

11. Providers will bill for agreed upon amounts at monthly intervals unless agreed otherwise, e.g., there may be some one-time expenditures which would require a larger (or a single) payment. Lump sum payments will be paid at the end of the fiscal year. **Providers can only bill for services provided**. If the service provided totals 1/12 th of the agreement then that amount may be billed for.
    A provider may not bill for 1/12 of an agreement amount each month unless services were provided that total that amount.
    Billed services must reference the appropriate Waiver Funding Categories listed on pages 28 through 33 of the Community Supports Information Guide.
    Billed services must refer back to the individual plans of care

and reflect the funding categories listed on the Community Supports Service Agreement.

12. Within 30 days of entering services the individual plan will be written.

13. The Community Supports Agreement should be incorporated into the Individual Plan, or attached in place of the objectives page if it is written in sufficient detail. It should be reviewed by the IP team at least annually.

    An amended Community Supports Agreement is only necessary if the total dollar amount (bottom line) of the plan is changed or if the service change is significant. For example, if the person had been scheduled to receive Work Services and he and his IP team believe that it's more important to spend the funds on dental work, a new agreement must be written. If a family wants to pay for a vehicle repair with Respite dollars, even though that vehicle is used to transport the CS recipient to and from Work Services the CS Agreement will need to be revised. Any time there is a significant change in funding categories the Community Supports Agreement will need to be revised.

    Any additional supports proposed to be written into the IP that will result in additional responsibility and expense to the Community Supports provider(s) will trigger a re-negotiation of the Community Supports Agreement between the provider and the DDP Regional Manager. The maximum amount may only be exceeded when Private Duty Nursing is required or unusual transportation needs are necessary.

Transportation needs must be approved through the Unusual Request Committee.

14. Community Supports Agreement renewals for the next fiscal year may be sent with any Agreements negotiated after February. If they are in by June 1, they will be processed in time to bill against at the end of July.
15. New Community Supports Agreements with a July 1 effective date must reach the appropriate DDP office no later than June 1.

16. The original agreement date is the date the Regional Manager signs the agreement making it a formal contract between the Individual and the provider of services.

QUESTIONS TO ASSIST IN RENEWAL OF COMMUNITY SUPPORTS AGREEMENTS

Following are questions Case Managers should ask individuals and their families/friends/guardians as part of preparing a Community Supports Agreement for a new fiscal year.

1. Are your health and safety needs being met with the current plan?

2. Are the services and or supports committed to in the current plan being provided as expected?

3. Have your needs changed ? (Review the Risk/Needs Planning Assessment.)

4. Would you like to make any changes in the services you are currently receiving in next year's service agreement?

5. Would you like to make any changes in the dollar amounts needed in your next year's service agreement?

6. Would you like to change any providers? Do you need assistance?

The Case Manager should contact other IP team members to discuss how things are going and if changes might be needed.

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES PROGRAM
COMMUNITY SUPPORTS AGREEMENT AND AUTHORIZATION
(please print)

ORIGINAL AGREEMENT DATE:_____ REVISED DATE:_____RENEWAL DATE_____

Client Name: _____ SSN ____-____-____ AWACS ID: _____

Client Address: _____ Client Phone: _____ DOB:____/____/____

Case Manager: _____ Phone: _____

ELIGIBILITY INFORMATION

 Medicaid Eligible Date _____ Eligible for D.D. Services Determination Date:

 Not Medicaid Eligible SSI SSDI Other

 Meets level of care for the waiver

SERVICE DATA TABLE

Provider Name	*Services (list separately)	Start Date	Fund Source (XIX/GF)	Original Service Cost (per year)	Revised Service Cost (per year)	Disencumbered Dollars per Service	Payment Schedule (Monthly, Quarterly)	End Date

*homemaker, personal care, respite, residential hab, day hab, prevocational hab, supported employment, environmental mods, transportation, specialized medical/adaptive equipment, adult companion services, private duty nursing, social/leisure/rec, health/health safety/health maintenance, educational (Please specify)

Community Supports: Total Amount $_____Revised Amount $_____ Disencumbered Amount $_____

Service Narrative:

_____

_____

Revised Narrative: _____

_____

_____

_____

COMMUNITY SUPPORTS AGREEMENT CONDITIONS:

DEVELOPMENT DISABILITIES PROGRAM (DDP) is responsible for:
1. Authorizing services in writing prior to service initiation
2. Providing copies of the authorized agreement to all parties
3. Monitoring the delivery of services.

CASE MANAGEMENT is responsible for:
1. Initiating the development of the essential needs assessment and support agreement
2. Conducting an annual review of the agreement
3. Coordinating the individual planning process
4. Providing the consumer with the means and opportunity to exercise informed choice
5. Contacting the consumer on a regular basis to observe progress and determine satisfaction
6. Assisting the consumer to find alternative services should that become necessary.

CONSUMER is responsible for:
1. Actively participating in the development of the essential needs assessment and support agreement
2. Actively participating in services to achieve the goals established in the individual plan
3. Notifying the case manager should he/she wish to exit services
4. Providing the provider a minimum of 90 days notice (or as otherwise agreed by both parties) should the consumer wish to exit services
5. Cooperating with a plan to transition to another provider should that become necessary.
6. Agreeing that the services available under the terms of the Community Supports Agreement are adequate and appropriate to meet his/her health and safety needs at the agreed upon cost.

PROVIDER is responsible for:
1. Providing services at the cost agreed to in the support agreement
2. Providing services according to the Community Support Agreement and assigned responsibilities in the plan of care (IP or ISP)
3. Providing the consumer and his/her family with pertinent policies and procedures
4. Complying with all applicable federal and state laws, regulations and written policies
5. Giving the consumer and his/her case manager a minimum of 90 days notice (or as otherwise agreed by both parties) should the provider wish to terminate services and assisting the consumer to find other appropriate services in the community.
6. Agreeing that they can provide adequate and appropriate services to meet the individual's health and safety needs at the agreed upon cost in the Community Supports Agreement.

PROCEDURAL SAFEGUARDS:
Should a consumer have a disagreement with a staff member or with the provider's policies or procedures, the consumer, family member/guardian or Case Manager, on his/her behalf, will first discuss the issue with the staff member involved or an appropriate representative of the provider's administration. If the issue is not resolved satisfactorily, the consumer may utilize the provider's formal grievance procedure or discuss the issue with the full IP team, utilizing the appeal process, if necessary. Failing satisfaction through that process, upon request, the case manager will assist the consumer in filing for a Fair Hearing with the Department of Public Health and Human Services.

AVAILABILITY OF FUNDING:
All parties agree that the Department may unilaterally reduce those monies as necessary either to conform its total cost of services for the Community Supports Service plans with the funding for those plans provided by the Montana legislature or to apply to other Developmental Disabilities Program costs any portion of those monies that the Department determines will not be expended during the period upon the consumer. The parties further agree that by January 31 and again by April 1 of each year the Parties will review the pattern of expenditures for the Consumer under the Consumer's Community Supports plan to determine whether there will be a portion of the monies available through the plan that would remain unexpended on June 30.

Monies determined to be unexpended will be deducted by the Department from the Community Supports Agreement "Total Dollar Amount." The Regional Office will send written notification of the amount to be deducted from the plan to the Community Supports recipient and the provider.

All parties agree to the service plan, costs and conditions contained in this Agreement.

Consumer	**Date**	**Family Member/Guardian**	**Date**
Provider	**Date**	**Provider**	**Date**
Case Manager	**Date**	**Quality Improvement Specialist**	**Date**
Regional Manager	**Date**		

Revised Agreement Signatures **Renewal Agreement Signatures**

Consumer/Family Member/Guardian	**Date**	**Consumer/Family Member/Guardian**	**Date**
Provider	**Date**	**Provider**	**Date**
Regional Manager	**Date**	**Regional Manager**	**Date**
Case Manager	Date	Case Manager	Date

COMMUNITY SUPPORTS SERVICE DEFINITIONS

HOMEMAKER- Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

PERSONAL CARE- Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service. Payment will not be made for personal care services furnished by a member of the individual's family. Supervision of personal care providers will be furnished by a registered nurse, licensed to practice nursing in the State.

RESPITE- Respite care services are services provided to a recipient so as to relieve those persons normally caring for the recipient from the responsibility for the care of the recipients. Respite may be provided to an individual in his or her home, in the home of the Respite Provider, or in the community locations as specified in the Waiver document. The frequency and amount of Respite is included in the plan of care.

RESIDENTIAL HABILITATION- Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for Residential Habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety

code. Payment for Residential Habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

DAY HABILITATION- Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care. Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, Day Habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

PREVOCATIONAL HABILITATION- Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). When compensated, individuals are paid at less than 50 percent of the minimum wage. Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

SUPPORTED EMPLOYMENT- Consists of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving Waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving Waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting. Supported Employment Services furnished under the Waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2 Persons aged 18 and over who have been determined DD eligible under the Montana state definition would qualify for this service.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a Supported Employment Program;

2. Payments that are passed through to users of Supported Employment Programs; or

3. Payments for vocational training that is not directly related to an individual's Supported Employment Program.

ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS- Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would

require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.
Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual., such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

In addition to the above, Environmental Modifications Services are measures that provide the recipient with accessibility and safety in the environment so as to maintain or improve the ability of the recipient to remain in community settings and employment. Environmental Modifications may be made to a recipient's home or vehicle (wheelchair lift, wheelchair lock down devices, adapted driving controls, etc) for the purpose of increasing independent functioning and safety, or to enable family members or other care givers to provide the care required by the recipient.

An Environmental Modification provided to a recipient must:
(a) relate specifically to and be primarily for the recipient's disability;
(b) have utility primarily for a person who has a disability;
(c) not be an item or modification that a family would normally be expected to provide for a non disabled family member;
(d) not be in the form of room and board or general maintenance;
(e) meet the specifications, if applicable, for the modification set by the American National Standards Institute (ANSI)
(f) be prior authorized jointly by the provider's board of directors and the department if the cost of the project may exceed $4,000.

TRANSPORTATION- Service offered in order to enable individuals served on the Waiver to gain access to Waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace

them. Transportation services under the Waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

Transportation may also include escort services as a component of the Transportation Service, for the purpose of providing guidance and assistance to a person as outlined in a plan of care. Transportation Services may be provided by a family member for the purposes outlined in the plan of care. Reimbursable transportation expenses may also include assistance with reasonable (as determined by the department) costs related to one or more of the following areas: vehicle acquisition, maintenance, repair, operation (including operator training and licensure), insurance, registration or other costs associated with a recipient's dependence on the use of a personal vehicle owned by the recipient in accessing work or other community integration activities as outlined in the plan of care.

Because of the potentially large expense in assisting a recipient with the purchase of a vehicle, CS cost plan dollars for vehicle purchases will not be applied against the $7,800 cap. In other words, the cap may be exceeded when a recipient needs specialized services and a vehicle as outlined in the plan of care. In every case when the $7,800 will be exceeded, prior authorization from the Department will be necessary.

Guidelines for assessing the feasability of requesting funds to help with a vehicle purchase are as follows:

- is this a need?
- documentation Vocational Rehabilitation is unable to provide funding.
- verification the CS recipient has a valid driver's license.
- the vehicle must be in the individual's name.
- verification of funding source to pay for vehicle upkeep, i.e. gasoline, maintenance, insurance.

SPECIALIZED MEDICAL/ADAPTIVE EQUIPMENT EQUIPMENT AND SUPPLIES- Includes devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to

perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with Waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

ADULT COMPANION SERVICES- Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of Companion Services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

PRIVATE DUTY NURSING- Will be made available to individuals with chronic nursing needs for the hours specified by the physician in a private home, foster home, day program, job site or other community location as specified in the plan of care. The use of Private Duty Nursing for persons in Community Supports will be contingent upon a plan approved by the consumer/family/guardian, physician, service provider, and the Department.
NOTE- Nursing services costs will be separate from all other CS services in that these costs will not be factored into the maximum allocation of $7,800.

Nursing Services must be specified in the plan of care. It must be ordered in writing by the individual's physician and it must be delivered by a registered nurse (RN) or a licensed practical nurse (LPN). Nursing requirements and duties are further defined as follows:

(2) Nursing services may include:
(a) medical management;
(b) direct treatment;

(c) consultation; and
(d) training for the recipient or persons providing direct care.

Nursing Services must be provided by a registered nurse or licensed practical nurse. Persons providing Nursing Services must meet the licensure and certification requirements.

SOCIAL, LEISURE AND RECREATIONAL SUPPORTS- These services and supports are designed to address needs related to personal growth and development, community integration, formation of friendships, relationships and social skills and to enhance the quality of life of the individual. These supports often serve to provide primary care givers limited relief from the responsibilities of care giving and supervision. Reimbursements allowable in this category include those costs associated with the habilitation support and transportation directly associated with the social, leisure and recreational activities as outlined in the plan of care. Fees and equipment costs related to social, leisure and recreational outings are not reimbursable under the Waiver, or through State General Fund.

HEALTH, HEALTH MAINTENANCE, HEALTH SAFETY SUPPORTS- Supports available in this category include those services or supports which reduce known risks, as identified on a risk assessment completed annually as part of the Community Supports planning process and written into the plan of care. Supports in this category may include the purchase of such things as communication devices, e.g.,telephones and cell phones including hookups, deposits and monthly fees; emergency personal defense devices, monitoring devices and other safety related, risk reducing supports. Supports in this category may not be available through State Plan Medicaid Services or another Waiver service category but must relate directly to the needs of the Waiver recipient.

EDUCATIONAL SERVICES- This service is defined by adult learning activities such as classes, instruction, tutoring, distance learning, courses, instructional materials including books, software, Internet access fees, enrollment fees, tuition fees, supplies, or other expenses related to the education and skill development of the person as outlined in the plan of care. Relatives and family members may not be reimbursed for the provision of this service. Educational services available through VR or IDEA are not reimbursable with Waiver funds.

Note* Any CS request that provides an instructional component should be funded under the Educational category, e.g. ceramic classes, drivers license training, art classes but not art therapy. Therapies, swim passes, sports and health clubs should be funded through the Health and Health Maintenance category. Recreational outings, e.g. summer camp should be funded under the Social Leisure Recreational category.
If a social connection has an educational objective it must have an instructional component in order to be funded in the Educational category.

Equipment and supplies purchased for an individual through a CS Agreement belong to the individual they were purchased for.

Guidelines for Accessing Community Supports Dollars

Requests for Community Supports dollars will likely be for diverse and varied services and supports, some of which we may have never purchased under past service models. These guidelines will be of assistance in making decisions about whether the requested services/supports are a sound and valid use of Community Supports dollars. Additionally, applying these guidelines to each Community Supports request will bring some initial consistency and cost efficiency to the types of services/supports purchased.

Considerations for approval of Community Supports requests:

Community Supports service dollars are always used as "payer of last resort." Consider whether the request could/should be met through natural supports or through alternate sources of funding.

Consider whether the request is a "need" or a "want." The purpose of Community Supports is to "with reasonable expectation" meet the **health and safety needs** of individuals with Developmental Disabilities.

Consider whether the request enhances the individual's ability to be more independent and self-sufficient.

Consider whether the request is directly related to the accomplishment of a personal goal, or an outcome or objective from the IP.

Consider whether the funding request is an approved Waiver Service.

Consider whether there is a reasonable, lower cost alternative to the request. Is the request "reasonable and prudent" in its use of funds?

Remember that Community Supports dollars and services are not entitled.

When a request is denied, always offer reasonable alternatives or help in developing natural or other supports to meet the need.

Review Committee

Community Supports dollars will be used to purchase a variety of services and supports for individuals and their families to meet their "health and safety needs." ~Although many purchases will be for traditional services, there may be a variety of suggestions for innovative approaches to meeting individual personal health and safety needs.

Guidelines which can apply to individual proposals have been provided for individuals and their Case Managers, or other advisors (page 34). However, there may be some ideas that warrant an additional level of review, either because they are unusual, or because there may be concern about the appropriateness of the service within the approved Waiver funding category.

Anyone who is required to sign the Community Supports Agreement may suggest a review. The proposal should be sent to the Regional Manager who will convene a review committee to advise him of the appropriateness of the proposal.

Proposal Components

1. Describe the item or service that the individual needs.

2. State the cost.

3. Tell the committee:

    a. **why** this is important to the individual;
    b. **how** it will meet his or her health and safety needs; and,
    c. **why** more conventional ideas are not acceptable.

4. Include the opinion of others (e.g., a therapist, doctor, counselor, etc.), if relevant.

5. Include full name, phone number and address of the individual and his or her Case Manager.

Committee Membership

The committee makeup will be at the discretion of the Regional Manager. It must include an uninvolved person who is a family member or consumer, a Regional Office Staff person, and a Central Office Staff person. Additional, impartial community members may be included if determined necessary by the Regional Manager. In most situations a committee comprised of the required representatives will be adequate.

Procedure

The Regional Office will provide committee members with copies of the service proposal. The committee will meet in person or by phone. They may choose to telephone the individual or his or her Case Manager in order to understand the proposal better.

One person will volunteer to write the committee's consensus opinion that will be given to the Regional Manager. The summary should include the following information:

1. Recommendation for approval or disapproval; and,

2. The committee's rationale for its decision.

The Regional Manager will send his written decision to the individual and his or her Case Manager.

Decisions will be catalogued by the Regional Manager and by the Community Supports Coordinator at DDP's Central Office for future reference.

Appeal Process

Individuals who are determined inappropriate for the Community Supports Waiting List and the Community Supports Program are entitled to a Fair Hearing in accordance with ARM. 37.5.115. To request a Fair Hearing write to: Fair Hearing Office, Box 4210, Helena, MT 59604.

Community Support openings that are appealed will be filled by the next eligible individual on the Community Supports Waiting List.

Individuals determined appropriate for Community Supports through the Fair Hearing Process will be offered placement on the Community Supports Waiting List, or a placement in the Community Supports Program.

Community Supports (CS) Exit Policy

This policy is intended to guide individuals or providers when either chooses to discontinue the Service Agreement prior to the ending date of the Service Agreement.

Because the resources for purchasing Community Supports are allocated to meet the needs of the individual, when the person leaves services, the resources go with the person, and are available for the person to use elsewhere within the State.

Three types of **exit** may occur:

The individual chooses to leave the service/s of a provider.

A provider chooses to no longer provide a service to the individual. The individual would have the right to Fair Hearing with the Department when this occurs.

The individual's resource allocation is depleted. This would only be a temporary exit, in that the full allocation would be available to the individual at the beginning of the next fiscal year.

Recipients and providers are requested to give 90 days notice of intent to exit. However, special circumstances may warrant immediate exit from the program by either party. Should the provider wish to exit an individual from their services immediately, the recipient does have the right to the Provider Grievance and Fair Hearing process, as outlined in the Service Agreement (on page 26).

Community Supports services may not be exited until the recipient and the provider have been in the service a minimum of three months. Exceptions to this minimum requirement may be granted upon agreement of the service recipient and the IP Team which includes the provider. During the transition period, Community Supports dollars may be used to purchase alternative supports.

When an individual exits the Community Supports Program the

vacated opening remains in the region. If the individual has moved to another region and then exits services, the opening will remain in the region where the individual was last in service.

Community Supports (CS) Exit Procedure

Any type of exit activity must comply with the following procedure:

Service recipients or providers seeking either termination or non-renewal of the service agreement must notify all parties to the agreement including the provider/provider, recipients, and the Case Manager.

Either the Case Manager or full IP team will assist with transition to another service provider.

Notice of desire to transition from one service provider to another must be given 90 days prior to exit or as otherwise stated in the Service Agreement.

A transition payment to the prior provider may occur during this period if that provider is actively involved in assisting the individual in making a successful transition to the new provider and if there are funds available.

Transition payment to the provider will be negotiated with the provider by the Regional Manager. Payments to providers made during the transition period may not equal or exceed the cost of the Community Supports Service. The transition fee will be for the purpose of covering the cost of coordination and other types of services necessary to move a person from one provider to another.

Payment to the new service provider will start after delivery of services.

6. A Community Supports recipient who has given up OBRA Funding may resume this funding once the Community Supports Agreement is cancelled.

Closing Procedure

The Individual Service Record (ISR) should show the actual date that a person leaves a service. If porting to a new Region close the Agreement. A new service

Agreement must be written in the Region the individual ports to.

Invoices with costs incurred prior to the individual leaving a service should have a date prior to the date the person exited Community Supports. The Agency Wide Accounting System (AWACS) will accommodate these invoices as long as sufficient resources remain attached to the Agreement.

Funding Policy

Community Supports (CS) dollars will be allocated per individual on the Community Supports Waiting List up to the maximum amount. Each year a person is in Community Supports, that person will have the maximum amount allocated to him or her. The **maximum amount** is the allowable expenditure in Community Supports per person. The **allocation** is the amount of money required to meet health and safety needs and may not exceed the maximum allowable amount. The **maximum allowable dollars** will be prorated depending on the individual's start date. For example, a person starting services January 1, will have half of his or her maximum allowable dollars to spend through June 30.

Unallocated funds are dollars from any Community Supports Service Agreements where the individual's cost of service/s is less than the maximum dollars allowed**.** There can be three types of unallocated funds:

Those that are never allocated, i.e., CS services are refused in total. This means that an individual either refused services, or accepted placement in another category of DDP services, or died prior to accepting CS. An individual receiving services using never allocated CS funds will be able to receive services up to the maximum as long as the Agreement is entered into at the beginning of the fiscal year, otherwise the dollars will be pro-rated.

Those that are left when someone leaves CS services and hasn't used the full amount. This means that an individual used some of their allocation, but then left CS services prior to the end of the fiscal year. Depending on the circumstances, the Regional Office would either use the dollars remaining for one-time expenditures, filling the opening in July of the following fiscal year, or simply fill the opening with the next eligible person on the Community Supports Waiting List.

Those that are allocated but unused, i.e., the person remains in CS services but doesn't use full amount. The remaining funds will be discussed with the person. If he or she does not have further needs, the funds will be disencumbered. The remaining funds can then

be assigned elsewhere.

4. Funding source changes from General Fund to XIX or vice-versa require the agreement to be closed. Write closed at the top. Write the total number of dollars unexpended on the disencumbered line. Write a new agreement with the new funding source. Place the total disencumbered dollar amount on the total dollar amount line...DO NOT PUT ANY DOLLAR AMOUNT ON THE REVISED LINE OR THE DISENCUMBERED LINE. You are essentially creating a new agreement. Fill in the service data table. Add your service description to the narrative with the administrative charge follow the Regional Office procedures and forward a copy to the Central Office for processing.

Note* The Department will review cost plans by January 31 and again by April 1 of each year. Cost plan funds not spent or designated for timely expenditure must be disencumbered. Written notification of the amount to be deducted will be sent to the service provider and the Community Supports recipient.

Community Supports Disencumberance Process

(a) Highlight **" REVISED AGREEMENT DATE**" and enter the date the revision is effective,
(b) If client is closing/terminating services write this across the top,
(c) In the space after "Revised Dollar Amount" enter the total amount expended to date for the Agreement;
(d) Under "Service Narrative" write a brief explanation for disencumbering the funds and submit paperwork to the Central Office.

Use of Crisis Dollars for Community Supports Recipients

Persons in Community Supports who are also in crisis, may access Crisis Funds as is currently practiced with existing service recipients.

Service Exchanges

Service exchanges are available in Community Supports for any DDP funded adult service, as long as the health and safety needs can be met for both individuals involved in the service exchange. Please follow the same procedural guidelines that apply to other services. Service exchanges are encouraged, as long as both parties health and safety needs can be met.

Payment Mechanism

Community Supports Services are designed for all payments to be made

individually to each service provider on behalf of the person receiving the service. All services and costs are pre-authorized through the use of the Community Supports Agreement which has been signed by all the involved parties.

Each provider will be enrolled in AWACS as currently occurs. If a provider is enrolled in AWACS as a provider for any Department of Public Health and Human Services (DPHHS) program/division then this provider is enrolled in AWACS for federal reporting purposes for the Developmental Disabilities Program (DDP). Each recipient's information will be entered into AWACS through the Individual Service Record (ISR) as currently occurs. This includes demographic information, past, current and waiting for services information and ICAP data. The individual will be entered as receiving Community Supports Services. The Community Supports Service category number is fourteen (14). Updating the individual's information will occur through the use of a revised ISR as happens now. ISR's will be updated for all individuals in the Community Supports Services pool at the time their Service Agreements are finalized. ISR's are completed by the DDP Regional Office Administrative Assistants. Consumer and provider/service Information is supplied to them by Case Managers, Quality Improvement Specialists, or Family Support Specialists.

Once a provider is enrolled, an individual is entered and a Service Agreement has been loaded, then AWACS is ready to process payments. One invoice for each authorized individual will be pre-printed. Providers will specify, on the Support Agreement, how often they desire an invoice to be pre-printed with choices being monthly, quarterly, semi-annually or annually. The choice of frequency can vary with each individual the provider serves. The pre-printed invoices will be mailed to each provider usually by the end of the third week of the month.

The provider will invoice for the services provided to each individual for the previous time period on the pre-printed invoice. This invoice should be submitted by the end of the second week of the month after the month that services were delivered. The invoice cannot be submitted prior to the end of the time period of services.
The completed invoice will be submitted to the DDP Regional Office for review and approval. After entry and approval in AWACS, an electronic fund transfer will occur or a warrant will be generated. A Statement of Remittance (SOR) will be generated and mailed. As currently occurs, only one transfer or warrant will be generated for each provider each month. Providers with multiple invoices for Community Supports and invoices for other DDP-funded services will have all of

these payments grouped into one warrant or transfer unless special circumstances require more than one. No advance payments will be made so a provider needs to have sufficient cash flow.

Invoiced dollar amounts must be broken out in the appropriate service categories on the invoice data table.

Administrative costs must be reported in the service narrative of the Community Supports Service Agreement for each service purchased. Administrative costs are indirect costs that benefit common activities and cannot be readily assigned to a specific direct cost objective or project. Indirect costs for non-profit organization include general administrative costs, e.g. (Director's office, payroll, accounting) and facility costs, e.g. (rental costs, operations and maintenance, interest expense).

Positions applicable to services under contract with the DD Program should be classified as either Administrative or Direct Care. If an individual performs in both Administrative and Direct Care activities, funds should be allocated proportionateley.
Administrative Staff refer to those individuals who primarily perform duties in support of the operation of the organization as "Administrative Personnel", e.g. Administrative Assistants, Directors, Fiscal Staff, Program Managers, Janitors.
Direct Care Staff refer to those individuals who perform "hands-on" delivery of services to individuals with Developmental Disabilities, or to their families, e.g. monitoring and delivery of life and health care needs, implementation of programs, recording progress towards goals and objectives, documenting incidents and sharing information with appropriate staff, or other professionals in compliance with established policies and procedures.

Audit of compliance requirements and related objectives are conducted under OMB Circular A-133.

PHHS/DDP/100X
Rev (2/99)

STATE OF MONTANA
DEPT. OF PUBLIC HEALTH & HUMAN SERVICES
DEVELOPMENTAL DISABILITIES PROGRAM
PO BOX 4210 HELENA, MT 59604

INDIVIDUAL SERVICE RECORD

Complete this form whenever an individual first enters services, re-enters services, or a change occurs in the status of a currently served individual. For currently served individuals, only enter information which has changed. **For all individuals, enter new or changed waiting list information.**

INDIVIDUAL SOC. SEC. NO.	INDIVIDUAL NAME			BIRTHDATE		
	LAST	FIRST	MI	MO	DAY	YR

STREET ADDRESS	CITY	ST	ZIP CODE

DATE FIRST ENTERED PGM			LAST DATE EXITED PGM			REGION NO	COUNTY NO	COUNTY NAME	INDIVIDUAL ID
MO	DAY	YR	MO	DAY	YR				

SERVICE		WAITING REQUEST DATE			DESIRED START DATE			ENTER CODE	SERVICE START DATE			EXIT CODE	SERVICE TERMINATION DATE			DD CONTRACTOR NO	FUND SRCE	ELIG CODE	STATUS
CAT.	OPTION	MO	DAY	YR	MO	DAY	YR		MO	DAY	YR		MO	DAY	YR				

Answer the following questions if the individual is on a waiting list for services with the Program.

Accept service statewide? ____ (Y/N)

Geographic Area Choice of Service:

Town of 1st choice for service: _____

Town of 2nd choice for service:

Town of 3rd choice for service: _____

Town of 4th choice for service:

Town of 5th choice for service:

PHHS/DDP/58GYS

(Revised 05/96)

MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Helena, Montana 59604

INVOICE

PROVIDER/TAX ID	CONTRACT NUMBER	INVOICE DATE	INVOICE NUMBER

CONTRACTOR/PROVIDER	BILL TO
NAME	DD PROGRAM
ADDRESS	ADDRESS:
CITY, STATE ZIP	PHONE NUMBER:

Grant Individual Contract **Subtype =** **Category:** **Option:**

DATE MO DAY YR	INDIVIDUAL NAME	SSN	ELIG CODE	TOTAL COST
USE ADDITIONAL SHEETS AS NECESSARY		**TOTALS** ➧		

PROVIDER/CONTRACTOR APPROVAL:	DEPARTMENT APPROVAL:
I certify that the amount/s reflected on this invoice represent services actually furnished, that the individuals were eligible to receive said services and that payment has not been received.	**Comment:** **Approved Amount $** **Approved for Payment _____ Date:**

Contractor/Provider Signature	Date	

Annual Community Services Report (ACSR) - Instructions

As a requirement of Community Supports (CS) services, either General-Funded or DD Waiver-funded, providers must submit an Annual Community Services Report (ACSR.) This form is used to identify the total amount invoiced for persons enrolled in Community Supports. The ACSR is due September 30th for the fiscal year ended June 30th and is subject to general State Qualified Provider reporting requirements. This fiscal report is to be submitted to the Regional Office in which the services were provided. Upon review the Regional Manager will send this report to the State Central Office.

Invoices: Providers will invoice for the services provided each month, each quarter, or as specified in the Service Agreement.

Report Amounts Invoiced on the ACSR: The ACSR should reflect the cumulative dollar amount billed for each service that all individuals receive. Enter the monthly, total dollar amount charged to each applicable category.

The total amounts reported on the ACSR should be in agreement with actual amounts invoiced for the program for the year. In other words, the ACSR totals must equal the total dollars received. This would agree with payments in AWACS.

General Instructions: All services must be required by the Individual Plan and specified in the Community Supports Agreement. All Community Supports (CS) Services must meet Waiver guidelines. Services available under State Plan Medicaid must be accessed before providing those services under the Waiver.

Federal Regulations prohibit individuals receiving Waiver-funded Pre-Vocational Service (facility-based day service) from earning more than 50% of the minimum wage. The state approved formula for calculating whether or not an individual's earnings exceed the 50/50 rule is: (5.15 x 1040 = $5356.00). If an individuals annual earnings in a facility-based day service exceeds $5356.00, they are not eligible for Waiver-funded Pre-vocational Services. There is no earning limit for individuals receiving Supported Employment or who are General-Funded.

Total all categories Total all fifteen services by the month and by the individual services for all consumers served.

The ACSR reports are completed by Community Supports Providers. As mentioned previously, final totals on the ACSR should be in agreement with invoiced amounts for the program for the year.

As a final note, a computer-generated facsimile of the ACSR form is acceptable, and a Lotus or Excel spreadsheet is available upon request.

Annual Community Supports Report

CONTRACTOR: _____FY: _____CONTRACT ITEM ID #: _____

RECIPIENTS NAME: _____ SSN: _____

	July	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*April*	*May*	*June*	
SERVICES													**TOTAL**
Homemaker													
Personal Care													
Respite													
Residential Hab													
Day Hab													
Prevocational Hab													
Supported Employment													
Environ Access. Adapt.													
Transportation													
Spec Med/Adapt Equip													
Adult Companion													
Private Duty Nursing													
Social, Leisure & Recreational													
Health-Health Maintenance & Safety													
Educational Services													
TOTALS													

Signature of Person Responsible for Form Completion: _____

(Signature)

(Date)

History of Montana's Home and Community-Based Services

Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain Medicaid statutory requirements in order to enable states to cover a broad array of Home and Community-Based Services, not otherwise available under the Medicaid State Plan as an alternative to institutionalization. This provision was added to the statute as part of P. L. 97-35, the Omnibus Budget Reconciliation Act of 1981.

Prior to passage of P. L. 97-35, Medicaid funds were used only for services to people in hospitals, nursing homes, and institutions, with the result that individuals frequently were forced to seek services in those settings rather than in less expensive and often more appropriate community settings. The intent of the new legislation was to allow Medicaid payment to be made for Community-Based Services providing the same level of care that was provided by a medically-oriented facility such as an Intermediate Care Facility for persons with mental retardation (ICF/MR). It was felt that with this extra flexibility, many people who needed ICF/MR services could be provided with similar services in the community, thereby providing them with a better life as well as saving the government money.

P. L. 97-35 became effective at approximately the same time that the Department of Public Health and Human Services (then the Department of Social and Rehabilitation Services) received notice that Parkside Manor, a 52-bed ICF/MR in Helena, intended to close at the end of the 60-day notice period. Rather than require the Parkside residents to enter the state-run ICF/MR, Boulder River School and Hospital (now Montana Developmental Center), the State of Montana submitted a Waiver request to serve 38 of those individuals in the community. The Waiver request was approved by the Health Care Financing Administration (HCFA) with an effective date of December 2, 1981.

The State of Oregon also received a December 1981 approval. Both states claim to be the first state in the nation to have a Medicaid Waiver to provide Home and Community-Based Services.

The Department's second Waiver, beginning December 1, 1983, included services to persons who are elderly or physically disabled as well as persons with Developmental Disabilities. The second Waiver expired June 30, 1986. A year's extension was granted by HCFA.

At that time, the Economic Assistance Division of Public Health and Human Services applied for a separate Waiver to serve persons who are elderly or physically disabled while the Developmental Disabilities Program continued to work under the extended Waiver until the third Waiver to serve persons with Developmental Disabilities became effective July 1, 1987. The third Waiver, as amended, authorized services in FY90 to 315 individuals.

The fourth Waiver, effective July 1, 1990, as amended, has requested the authority to serve up to 1,332 individuals in Fiscal Year 2000. For the fiscal year ending June 30, 1999, the Waiver served 980 individuals at a cost of approximately $27,844 per person, on average well below that of the cost of institutional care.

The Community Supports Waiver was approved October 1, 2001. It is the first Waiver of its kind in the State of Montana serving 281 individuals with authority to serve 320. The Community Supports Waiver is considered to be cutting edge across the nation with its emphasis on flexibility, portability and client-centered choice with an array of available services within 15 funding categories.

The Waiver Program has grown to be an important part of Montana's Developmental Disabilities Service System, serving individuals who require services similar to those provided by ICF□s/MR. Those services provided include: intensive support coordination in Intensive Family Education and Support, supported living coordination in Supported Living, Residential Habilitation, Senior Day Services, Intensive Day Services, Pre-Vocational Services, Supported Employment, Transportation, Respite, and a variety of support services including Psychological Services, Physical, Occupational and Speech Therapy, Homemaker Services, Adaptive Equipment and Environmental

Modifications, Nursing, Personal Care, and Dietician Services.

When Montana became the first state with an approved Waiver Program, it did so as an alternative to developing plans for small, Community-Based ICF's/MR. As a result of the Waiver Program, the population in Montana's ICF's/MR (Eastmont Human Services Center and Montana Developmental Center) has declined.

The net effect of Montana's Waiver Program, therefore, has been to accomplish exactly what was proposed when it was originally approved by the Health Care Financing Administration: ICF/MR beds have been decertified, no new beds have been licensed, ICF/MR census has dropped, and a cost savings has been demonstrated through development of Community-Based Services that divert from institutional care, or de-institutionalize, those who would otherwise have no alternative.

General Restrictions on Utilization of Waiver Funds

Note: Services are subject to Federal audit. Also, with the exceptions noted below, all services, regardless of funding source, will have the following restrictions:

A. No Room and Board: Board means three meals a day or any other full nutritional regimen. Room means shelter-type expenses including all property related costs such as rental or purchase of real estate and furnishings, maintenance, utilities and related administrative services. Room and Board costs include motel and hotel stays overnight. Also, because creating living space is considered room and board, only General Fund may be used to pay for the creation of living space.

B. No Duplication: Waiver Services, including Waiver-Funded Day Programs, cannot be provided to residents of Nursing Facilities. The Waiver cannot pay for services that should be provided by schools or Vocational Rehabilitation. Note: Any services provided to persons residing in Nursing Facilities must be funded by State General Fund.

C. For facility-based Pre-Vocational Services, a person must earn less than 50% of the minimum wage.

Note: Any Pre-Vocational Service provided to individuals earning more than 50% of the minimum wage must be funded by State General Fund.

D. Payor of last resort, so:
   1. Access Medicaid services first;
   2. Access Vocational Rehabilitation first for time-limited vocational services. Community Support Services may be used to fund the long-term sign off; and,
   3. School provides educational services.

E. Equal charges for equal services, or if not, needs clear justification.

F. Services must be required by the plan of care.

G. A service recipient's immediate family members may not provide

services to the recipient as a reimbursed provider, or as an employee of a reimbursed provider. Immediate family members include:

i. a spouse; and,

ii. a natural or adoptive parent of a minor child.

The parent of a disabled adult may provide services as a reimbursed provider, or as an employee of a reimbursed provider, only if the parent is not the guardian of the disabled adult consumer. This also applies to siblings who acquire guardianship.

H. An individual's family member may not be paid to provide Personal Care Services. Refer to the Service Definition on Page 28.

I. Payment may not be made to an individual's immediate family member directly, or indirectly, for providing Residential Habilitation Services. Refer to the Service Definition on Page 28.

J. Payment may not be made to an individual's immediate family member, directly or indirectly, for providing Educational Services. Refer to the Service Definition on Page 33.

K. Payment may not be made to parents for tickets or fees to attend social /recreation/leisure activities with their adult sons or daughters.

L. Vacations and trips will not be funded with Community Supports dollars. Community outings that are tied to objectives in the Plan of Care may be funded through the Social/Recreational/leisure category. Rural communities that do not offer much in the way of social habilitative experiences can extend the boundaries to include nearby larger cities.

M. All costs will be agreed to and authorized by way of the Service Agreement, which must be signed by the Regional Manager. Questionable costs or services may be referred to the Unusual Request Committee established to review such issues.

Qualified Provider Policy

All providers must be "qualified".

accreditation from either The Council on Quality or The Rehabilitation Accreditation Commission (CARF) in any program service area is optional. ARM 37.34.1801(10) lists several services that are exempt from the Accreditation Rule.)

Qualified Providers must satisfy requirements of the State quality assurance process and annual review by a State Quality Improvement Specialist.

Thus a "Qualified Provider" of Community Supports must satisfy the following requirements:
First Aid training;
CPR training;
Acceptable background check;
Satisfactory driving record; proof of acceptable levels of insurance (general liability, worker's compensation and motor vehicle liability);
Business account with proof of financial solvency, including the ability to make a projected two to four month payroll, including employment taxes;
A written contingency plan, approved by the Department, addressing service delivery to recipients in a timely manner or in the event the provider ceases operation;
Required program training as provided by DDP; and
h. Liability insurance for purposes of bonding, if necessary;
I. Individualized on-call system;
j. Business must be registered with the Secretary of State.

Note* non-profit status is required only if a provider is operating group homes. A CS Provider may be a legal entity as a Corporation (LLC) or Partnership (LLP). The Developmental Disabilities Program does not contract with Sole Proprietors.

A legal entity such as a school district, in certain situations, may qualify to be a Community Supports Provider and should follow contracting guidelines as outlined in this section.

Application To Become Qualified DDP Community Supports Provider

(The completion of this form is necessary prior to the initiation of any service bya new provider.)

Name of Entity: _____ Entity Representative:

Date of Application: __/__/

The attached current documentation from the Department of Labor is proof of either "independent contractor" status or an exemption from such.

All of the following requirements, as determined necessary (by the Case Manager, Quality Improvement Specialist, and/or family) to meet the needs of the individual/s to be served have been satisfied, with documentation provided to the Regional Manager:

a. First Aid trained - **Direct Care staff only**
b. CPR trained - **Direct Care staff only**
c. Acceptable background check - **Direct Care staff only**
d. Satisfactory driving record; proof of acceptable levels of insurance (general liability and motor vehicle liability) **- Direct Care Staff**
e. Proof of financial solvency, including the ability to make a projected two to four month payroll **-**
   Provider
f. A written contingency plan (approved by the Department) addressing service delivery to recipients in a timely manner or in the event the provider ceases operation (or for whatever reason cannot provide the service) **- Provider**
g. Will accept monitoring by the Department, using the requirements specified in the Quality Assurance Review **- Provider**

All of the following program training has been completed as documented by a Quality Improvement Specialist:

a. Abuse prevention and abuse reporting;
b. Incident reporting;
c. Client rights;
d. Confidentiality;
e. I P process;
f. Medication Administration Rule;
g. Information on any other applicable Rule: (Please state Rule cite and title:

Exceptions to any of the above and justification/s:

Form completed by:

(Quality Improvement Specialist Signature)

Approved/Not Approved (Circle Selection):

(Regional Manager Signature/Date)

QUALITY ASSURANCE

The following consumer surveys are to be used annually for all recipients in Community Supports Services. Choose the survey form which best meets the needs of the individual being surveyed. These forms must be retained in the client file and a copy is to be sent to the Quality Assurance Specialist in the Developmental Disabilities Program Central Office.

Form CMS- 001
Consumer Survey For Community Supports Services

Name:
Relationship to Consumer:
Address:
Service Provider:
Service:
Date(s):

The following questions are designed to assure that the consumer's health, safety and needs are met through Community Supports Services. Use all questions for each person in Community Supports.

Consumer Questions (if the individual is able to communicate with you, these questions are open-ended).

1. Who helps you where you live? Work?

2. Who are some of your favorite people? What do you like about them?

3. Are there things that happen that you don't like? What are they?

4. Does anyone ever yell at you? Who?

5. What are some of the nice things people do for you?

6. Do you like living/working here? Why?

7. Are you ever afraid of anyone (who)? Of anything (what)?

8. Who do you talk to if you need help at home? At work? In the community?

9. Who do you talk to if you don't like someone or are have problems with someone?

10. Who visits you?

11. What are some of the things you do for fun?

12. Does anyone take your stuff without it being okay with you?

13. Can you get your own food/drink where you live?

14. Do you ever give other people money, your stuff, cigarettes, food, etc? If so, what for and to whom?

15. Do people come into your home/bedroom without knocking? Who?

16. If the staff don't show up, who do you call?

17. What would you really like to be able to do? What do you wish

for?

FORM CMS - 001

Name:
Relationship to Consumer:
Address:
Service Provider:
Service:
Date(s):

The following questions are designed to assure that the consumer's health, safety and needs are met through Community Supports Services. Use all questions for each person receiving Community Supports.

Consumer Questions: (these questions require a simple yes/no answer and could be used with individuals who consistently respond to yes/no).

1. Do you have nice staff to help you at home? At work?

2. Is anyone mean to you at home? At work? (If yes, go through names of the peers/staff in the daily environment).

Do you like where you live? Work?

4. Are you ever afraid of anyone? (If yes, go through names of peers/staff in the daily environment)

5. Can you get help when you need it? From staff? From Case Manager?

6. Can you get your own food/drink?

7. Do people come into your house/bedroom without knocking/ without permission? (If yes, go through names of peers/staff in daily environment).

8. Do other people ever take things from you (i.e., cigarettes, money, food, pop)? (If yes, go through names of peers/staff in daily environment).

FORM CMS - 001

Name:
Relationship to Consumer:
Address:
Service Provider:
Service:
Date(s):

The following questions are designed to assure that the consumer's health, safety and needs are met through Community Supports Services. Use all questions for each person receiving Community Supports.

Support System Questions are to be used where the person is unable to respond for her/himself (these could be for family, guardians, advocates, staff, case managers, friends, etc).

1. Who are some of the people in the person's life who help the person? What do they help with?

2. Are there some people (peers/staff) they like better than others? Why?

3. If there are some people (peers/staff) they don't like, why is that?

4. Are there any needs currently not being met? Are they health and safety related? Who do you talk to about these concerns?

5. Does the individual have input into their life? To whom/how?

6. Do you have the opportunity to provide input? To whom/how?

7. If you have concerns, who do you talk to? Are the concerns resolved? Can you

share an example with me?

8. What are this person's wishes and dreams? Is there a plan in place moving in that direction?

9. What would make things better for the person?

10. Does the individual ever seem afraid? Are you ever afraid for them?